Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON, TEXAS 77029

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-1352-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. The denial code and their description are too vague for our facility to determine the basis for the denial. **This denial is not in compliance with Rule violation of rule §133.3.**"

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The dispute concerns reimbursement for review of a 2/11/10 designated doctor report in the capacity of treating doctor. 2. The treating doctor from 1/1/10 through 8/13/10 was Dr. G. Wali, M.D. (Exhibit) For this reason no payment was made for code 99455 bill by the requestor, Dr. S. Syed M.D."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2010	99455 VR	$50.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 07, 2010
   - CAC-W1 – WORKERS COMPENSATION FEE SCHEDULE ADJUSTMENT
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE.

Issues

1. Has the billing for Treating Doctor's Agreement or Disagreement with Another Doctor's Certification been denied appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The Requestor is billing as the treating doctor has performed a review of the examining doctor's Maximum Medical Improvement/Impairment (MMI/IR) exam. Per 28 Texas Administrative Code §134.204(j)(6), "The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50." Also, Per 28 Texas Administrative Code §134.204(n)(10) states "VR, Review report--This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only." However, the requestor is not the treating doctor of record at the time of the date of service for this injured worker. The respondent's use of "CAC-W1" and "892" are appropriate audit denials as the service is only to be billed by a treating doctor.
2. Review of the DWC records of treating doctors supports respondent claim that the billing physician was not the treating doctor. The requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.